Readmissions to same facility within 24-hours will be handled as one inpatient stay. Only one DRG will be reimbursed.

Medicaid Readmissions Note:

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Notice: Please Update Your Records

Our Address Has Changed

As of January, 2018, The Health Plan is settled in to our new location in downtown Wheeling. Please check your records to ensure you have our correct mailing address. ALL correspondence should be sent to the following address: 1110 Main Street, Wheeling, WV 26003.

**Incorrect Addresses:**

The Health Plan  
PO Box 4816  
Massillon, OH 44647

The Health Plan  
52160 National Road East  
St. Clairsville, OH 43950

The Health Plan  
PO Box 669  
St. Clairsville, OH 43950

The Health Plan  
52180 National Road East  
St. Clairsville, OH 43950

**Correct Address:**

The Health Plan  
1110 Main Street  
Wheeling, WV 26003

Also, please note the capital “T” in our company title. Any communication to our attention should be addressed to The Health Plan, not Health Plan or the Health Plan.

Thank you for your prompt attention to this matter. If you have additional questions, please contact Provider Relations at 1.887.847.7901
We are committed to ensuring that our provider network is sufficient for members to receive care in a timely manner. Annually, quality management staff monitor access and availability through phone and on-site surveys.

**Standards for primary care appointment accessibility include:**

- Regular/routine/preventive appointments: (ex: well exams, preventive care) should be seen within 30 days of a request to be seen.
- Routine follow-up/not preventive appointments: (ex: a medical concern such as blood pressure checks, wound check) should be seen within 21 days.
- Urgent care appointments: (ex: disabling symptom such as burns, strains, sprains) should be seen within 24 hours.
- Not urgent/not emergent appointment: (ex: symptomatic care such as flu, cold, sore throat) should be seen within 72 hours.
- Emergent appointment: (ex: dramatic increase in mortality/morbidity such as chest pain, heart attack) should be seen immediately. If unable to see patient immediately, they may be directed to emergency services/ER.

**Standards for behavioral health appointment accessibility include:**

- Routine appointment: (ex: patient condition considered stable) should be within 10 business days.
- Urgent appointment: (ex: worsening symptoms or new symptoms that if not treated could result in a more intense level of treatment) should be within 48 hours.
- Non-life-threatening emergency appointment: (ex: extreme emotional disturbance or behavioral distress, considering harm to themselves or others, out of touch with reality, compromised ability to function) require prompt attention, should be seen within six hours.
- Follow-up routine care to evaluate patient progress and other changes that have taken place since their previous visit. Within 30 days of previous visit.

**Standards for obstetrician perinatal care appointment accessibility**

- Initial visit appointment: should be 8-10 weeks of pregnancy or earlier if high risk for ectopic pregnancy.

**Waiting times within a primary care site should meet the following standards:**

- Appointment waiting times should not exceed one hour for scheduled appointments.

**24-hour telephone coverage:**

The provider is responsible for arranging on-call and after-hours coverage to ensure 24-hour telephone access to all members. All participating providers are required to maintain 24-hour, 7 day a week telephone access for their patients. The standard for returning a member call is 30 minutes.

For additional appointment accessibility and availability of care guideline information, please visit The Health Plan website at healthplan.org/providers/products & services/quality-measures.

Please be sure that your staff is also familiar with the appointment accessibility and availability standards.
Now Available: Electronic Pre-authorization

The Health Plan is happy to announce that we are now capable of electronic pre-authorizations via 278 transaction sets and the secure provider portal.

To utilize the 278 transaction set, you must submit a request and complete an EDI form.

To submit a pre-authorization using the secure provider portal, you must be registered on our secure portal. Once you log in, follow the prompt to “move your account” to the new portal. Once this process is complete, you will have the ability to submit pre-authorizations online!

Are You Ready for Changes? Medicare Beneficiary Identifier (MBI)

Effective April 1, 2018, the new 11-character Medicare Beneficiary Identifier (MBI) will replace the 9-digit Social Security Number (SSN)-based health insurance claim number for transactions such as:

- Intake and updating Medicare accounts;
- Eligibility status;
- Filing claims and billing; and
- Claim status (after a transition period).

The MBI will contain letters and numbers, for example: 1EG4-TE5-MK73

- The MBI’s 2nd, 5th, 8th and 9th characters will always be a letter.
- Characters 1, 4, 7, 10 and 11 will always be a number.
- The 3rd and 6th characters will be a letter or a number.
- The dashes aren’t used as part of the MBI. They won’t be entered into computer systems or used in file formats. MBIs will fit on forms the same way HICNs do. You don’t need spaces for dashes.

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By replacing the SSN-based identification number, we can better protect members’ private health, benefit, and financial information. Learn more about these changes and what you can do to prepare by visiting CMS’s website: https://www.cms.gov/Medicare/New-Medicare-Card/.

REMINDER: CMS Annual Training Requirements

CMS requires documentation from our providers of the completion of the fraud, waste and abuse (FWA) compliance training on an annual basis. This will assist in meeting the regulatory requirement for training and education. The FWA training is a requirement of the Social Security Act, CMS, Office of Inspector General (OIG), and HIPAA privacy regulations, as well as state Medicaid programs.

- The training must be completed within 90 days of the initial hire or the effective date of contracting and at least annually thereafter.
- You are required to maintain evidence of training for a period of no less than 10 years; this may be in the form of attestations, training logs or other means determined by you to best represent completion of your obligations.

To view the training module for FWA, or for additional Compliance and FWA resources, go to CMS MLN at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

REMINDER: THP’s Provider Manual

You can access The Health Plan’s Practitioner Manual online 24 hours a day, 7 days a week.

REMINDER: Signatures, Credentials and Dates Are Important

Each entry in the patient’s medical record requires the acceptable signature, including credentials and the date of the person writing the note.
What you Need to Know

THP’s Special Needs Plan (SNP)

Since January 1, 2014 The Health Plan administers a Medicare Special Needs Plan for members who have a chronic condition. The special needs population are recipients who qualify for both Medicare and Medicaid. These “dual eligible” members are individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program.

The Health Plan received approval as a contracted MAPD plan that is offering a new SNP program by completing a Model of Care (MOC) for CMS. This approval applied to the Dual Eligible Special Needs Plan (D-SNP).

The Health Plan has developed the MOC to provide comprehensive care management to members enrolled in D-SNP. The Health Plan’s MOC is a written document that describes the measurable goals of the program, along with The Health Plan staff structure and care management roles; the interdisciplinary care team (ICT) and the use of clinical practice guidelines and protocol; training for personnel and our providers; a health risk assessment tool to collect information; the development of an individualized care plan, communication efforts, and care management for the most vulnerable subpopulations; and performance and health outcome measures.

Measureable Goals* of THP’s D-SNP Program
- Improve access to essential services including medical, behavioral health and social services by providing a comprehensive network. Every SNP member will be assigned a case manager with social services readily available.
- D-SNP members will select a primary care physician, as well as be assigned a case manager from The Health Plan.
- Streamline the process of transition of care across healthcare settings, providers and health services coordinated by the physician/provider and the care manager.
- Improve access to preventive care
- Improve member health outcomes through participating annual HEDIS data collection as well as member surveys.

* These goals are just a brief description of some of our measurable goals.

Provider Reimbursements and Billing

Providers can bill The Health Plan for medically-appropriate covered services provided to the D-SNP member. The Health Plan will reimburse the provider for services rendered according to the member’s benefit plan, excluding any copays, co-insurance or deductible amounts. The provider will then be eligible to submit any balance associated with the copays, co-insurance and deductible directly to West Virginia or Ohio Medicaid program.

Provider Education

Provider education will be conducted by several approaches: face-to-face, web-based training, seminars and ProviderFocus newsletter articles. Additional information regarding the SNP’s program will be forthcoming.
Project ECHO
Improving Rural Healthcare

Project ECHO is a free program that utilizes a hub-and-spoke knowledge-sharing network to connect rural healthcare providers seeking advice on cases with experts in a specific disease state at West Virginia University. Sessions are held twice a month via video conference and provide rural healthcare providers an opportunity to present cases and participate in didactics covering a variety of topics.

Currently, Project ECHO is addressing chronic lung disease, MAT, psychiatry, hepatitis C and chronic pain treatment throughout rural West Virginia and Ohio.

**WV Project ECHO Chronic Lung Disease:**
First & Third Mondays 8 a.m. to 9 a.m.

**WV Project ECHO Medication Assisted Treatment:**
Second & Fourth Mondays 4 p.m. to 5 p.m.

**WV Project ECHO Psychiatry:**
First & Third Wednesdays 4 p.m. to 5 p.m.

**WV Project ECHO Chronic Pain:**
First & Third Thursdays 12:15 p.m. to 1:15 p.m.

**WV Project ECHO Hep C:**
Second & Fourth Thursdays 12:15 p.m. to 1:15 p.m.

Learn more by visiting the West Virginia Clinical and Translational Science Institute’s website. If you would like to participate or submit a case to Project ECHO, please contact Jay Mason at jdmason@hsc.wvu.edu.

New BMS Guidelines

**New Cultural Competency Requirements**

As a contracted health care provider, our expectation is for you and your staff to gain and continually increase knowledge and skills with improved attitudes and sensitivities to diverse cultures. This results in effective care and services for all members by taking into account each person’s values, conditions and linguistic needs. Your level of cultural awareness helps you modify your behaviors to respond to the needs of others while maintaining a professional level of respect, objectivity and identity.

The Health Plan’s goal is to enable optimal relationships that connect the care between our members and health care providers. BMS now requires that all providers complete cultural competency training. THP will begin tracking network providers to ensure compliance with this regulation. Training materials and an attestation form are available on healthplan.org. Attestation from another MCO’s website or proof of attendance at a seminar is acceptable in satisfying this requirement.

For specific requirements and expectations, refer to our website at healthplan.org/providers.

THP will host a cultural competency webinar on February 13 at noon. Invitations will be sent via email two weeks prior to the webinar. If you are unsure if THP has your email address, contact us to verify your email address with our Provider Relations Department at 1.800.624.6961.

Member Rights and Responsibilities

We would like to remind all provider offices that the member rights and responsibilities can be found in the Provider Procedural Manual, Section 3. This manual is available on our website, healthplan.org. If you would like a copy please contact Provider Relations Customer Service at 1.800.624.6961, ext. 7901.
2017 Practitioner Experience Survey
The Results are In

In 2017, The Health Plan sent out 684 online practitioner experience surveys to primary care physicians (PCP), behavioral health practitioners, and secondary care physicians (SCP). The goal of this survey is to identify areas that we can improve regarding our Medical Management programs. The results are analyzed and compared to the prior year.

We received 39 responses for a return rate of 5.7 percent, which was a 6.9 percent decrease over 2016. The return rate remains low.

Despite the low response rate, questions regarding referrals, criteria, medical directors, care/complex case navigation and chronic disease navigation were all above the 90 percent benchmark and remain consistent.

If you have questions or concerns, contact the Medical Management Department at 1.800.624.6961, ext. 7644 or 7643 or Behavioral Health Services at 1.877.221.9295.

Billing Information
Low Income Medicare Beneficiaries

The Qualified Medicare Beneficiary (QMB) program is a Medicaid benefit that pays Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans.

If you are a PCP, THP has coded your patient rosters with a symbol to help you identify which of your patients meet this income level. Patient rosters are available on our secure provider portal located at healthplan.org/providers.

Patients should make their providers aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. The patient should not get a bill for medical care that Medicare covers. Patients cannot be charged for Medicare deductibles, coinsurance and copayments.


Behavioral Health
Member Satisfaction Survey

A member satisfaction survey of members who participated in behavioral health case management from May 2016 to April 2017 has been completed. Although the return rate of surveys was on 27.8 percent, all participants in the survey rated the program and the nurse navigators highly.

All questions were answered positively. All personal comments were favorable regarding the program and nurse navigators.

If you have questions about case navigation, call Behavioral Health Services at 1.877.212.9295.
Coordinated Care

As outlined in Section 8 of THP’s provider procedural manual, Continuity and Coordination of Care, we believe that the care our members receive should be seamless from one setting to another. We encourage our members to keep their PCP informed of any change in their medical condition including visits to an intermediate, skilled or rehab facility; an inpatient or outpatient center; an emergency room or urgent care setting; a VA clinic, health fair, mental health care provider or specialists as well as any tests, medications or treatments that were recommended. We also strongly encourage the PCP to ask the member about these and to clearly communicate with any specialist.

For improved continuity and coordination of care, we suggest the following:

• Specialists and/or PCP mail or fax updates as needed and include the information in the patient’s medical record
• Phone consultation or conference calls when multiple doctors are involved in the member’s care
• Concise documentation in the medical record to show that PCP/specialist consultation has occurred
• For our behavioral health members, our behavioral health providers are encouraged to discuss with their patients the importance of sharing their behavioral health care issues with their PCP. A release form is available by calling Behavioral Health Services at 1.800.624.6961, ext. 7301 or on our website.

Review of Your Practice Information

The Health Plan strives to provide the most updated information to our members regarding our network provider information such as physical location, telephone number, hospital affiliation, is the provider accepting new patients, and any other restrictions you may have. Confirmation of what lines of business your practice participates in is also vital. Follow these steps to verify your information:

1. Log on to http://findadoc.healthplan.org/.
2. Search by LAST NAME and ZIP CODE or STATE. Our system will show all practitioners with the same last name. Select the provider to view all of the current information available on our system. If you do not have access to the Internet, simply give us a call and we will gladly review the information relative to your practice. Large groups may call us to request a report of all providers linked by tax number.
3. Any changes should be reported in writing. Please fax changes to 740.699.6169 or email hpecs@healthplan.org.

Note: This notice will be generated quarterly to satisfy CMS reg. §§ 422.111 and 422.112 along with the Ohio Department of Insurance.

Notice: ABN Forms for Medicare Advantage

ABN forms cannot be used for patients that are insured by a Medicare Advantage plan.

For patients insured through our SecureCare plans, follow the process outlined in Section 3 of THP’s provider procedural manual, Noncovered Service Guidelines.
Guidelines

Fax Facts

When faxing notifications to The Health Plan, please follow these guidelines:

- **Inpatient/Observation Admit:**
  For notifying THP of an inpatient/observation admit, fax a copy of the hospital admission face sheet to **740.695.5297**. Follow-up clinical review should be faxed to **330.830.4397**.

- **Referrals:**
  When faxing information to obtain a new referral, send to **740.695.5297**. Be sure to include in the cover sheet if the fax is for a new referral and which services you are requesting.

- **Pre-authorization Requirement Changes**

  Effective March 1, 2018, the following changes will be made to The Health Plan’s pre-authorization/pre-notification requirements.

  - Home health services will no longer require pre-authorization during the first certification period. If services are to extend past the first certification period (60 days), pre-authorization is required prior to the start of the second certification period.
  - Wound care professional services/wound care clinic office visits will no longer require pre-authorization.
  - Psychotherapy visits will no longer require pre-authorization. This update pertains to all lines of business, however, certain self-funded (ASO) groups may continue to require pre-authorization.

  Call **1.877.221.9295** to clarify any questions that you may have. Any requests for psychotherapy which are received from the date of this notice until the behavioral health pre-authorization list and Medicaid behavioral health provider manual have been updated will be approved without any clinical review.

  Pre-authorization notice of changes, lists and forms can be found at [healthplan.org/preauth](http://healthplan.org/preauth).

Unlisted Procedure Code 41899

Medicaid Hospital Dental Procedures

For members under the age of 21 that require dental services to be rendered in a hospital setting, the dental provider is required to obtain a prior authorization from Scion Dental for the procedure. Once the provider obtains the prior authorization from Scion Dental, the hospital services are required to be authorized through The Health Plan. Providers will need to contact Customer Service to obtain the prior authorization. The authorization number from Scion Dental will be required when requesting the authorization from THP.

For members over the age of 21, prior authorization is required for this procedure. Please contact Customer Service. Adult dental benefits are limited to emergency extractions only.